



Non-Insured Health Benefits Completion of Active Orthodontic Treatment Form

Provider Information

Name: _____ Provider Number: _____

Mailing Address: _____

Client Information

Name: _____ Client Registration Number: _____

Mailing Address: _____ Date of Birth: _____
(YYYY-MM-DD)

1. Date active orthodontic treatment started (YYYY-MM-DD): _____

2. Date active orthodontic treatment completed (YYYY-MM-DD): _____

3. Was the original orthodontic treatment plan changed? YES NO
If yes, please explain: _____

4. Were the objectives of the orthodontic treatment plan accomplished? YES NO
If no:
a. Please explain: _____
b. Please provide a list of services rendered since orthodontic treatment was initiated including their date of service. (Please attach separate sheet if needed) _____

5. Were retainers inserted? YES NO
If no, please explain: _____

6. What is the projected duration of retention phase of orthodontic treatment? _____

7. Does the client require additional dental services (restorative, periodontal, etc.) YES NO
If yes, please explain: _____

I confirm that the above information is complete and accurate.

Provider Signature **Date (YYYY-MM-DD)**